CRIME VICTIMS REPARATIONS
MEDICAL EXPENSE VERIFICATION FORM

THIS FORM IS TO BE COMPLETED BY PROVIDER'S BUSINESS OFFICE

CVR NUMBER:

VICTIM:

VICTIM SSN:

CLAIMANT:

DATE OF CRIME:

Sheriff's Claim Investigator:

Address:

Phone:

CLAIM INVESTIGATOR INSTRUCTIONS:
1) This form may be sent in lieu of phone verification of medical expense.
2) Send a copy of this form and the "Authorization To Release Information " to each medical provider listed on the claim form.
3) Attach the completed verification form(s) to the claim form and checklist before forwarding to the CVR Board Office.

MEDICAL PROVIDER INSTRUCTIONS:
1) This form is to be completed by the business office.
2) A Crime Victims Reparations claim has been made under the Louisiana Crime Victims reparations act at LA R.S. 46.1801-1822 by the above named victim for injuries sustained on the date shown.
3) The completed form is to be returned to the sheriff's Claim Investigator at the address shown.
4) The Louisiana Crime Victims Reparations Board does not act as guarantor for any service rendered.
5) Insurance payments must be credited before completion of this form.

TOTAL CHARGES FOR SERVICE TO DATE: $ _____

PAID BY PATIENT: _____

PAID BY INSURANCE: _____

INSURANCE ADJUSTMENTS: _____

OTHER PAYMENTS(EXPLAIN ON BACK): _____

CURRENT BALANCE $ _____

TYPE OF SERVICE:

□ HOSPITAL □ IN-PATIENT

□ PHYSICIAN □ OUT-PATIENT

□ DENTAL □ OTHER

NAME AND ADDRESS OF PATIENT'S INSURANCE:

_____

_____

_____

POLICY NUMBER: _____

GROUP NUMBER: _____

PHONE NUMBER: _____

NAME AND ADDRESS OF POLICY HOLDER: _____

_____

IF THE PROVIDER IS A HOSPITAL, ATTACH THE FOLLOWING DOCUMENT(S) TO THIS FORM:
*** EMERGENCY TREATMENT AND * FINAL DISCHARGE REPORT**

_____
AUTHORIZED SIGNATURE

_____
PRINTED NAME

_____
TITLE

_____
DATE PHONE

_____
BUSINESS NAME

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
FEDERAL EMPLOYER IDENTIFICATION NUMBER